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Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

Preconception Health: From Concept to Measurement to Action

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ANNETTE PHELPS: Good morning everyone. Those periods of having to wait always feels awkward to me and yet it should be a time when we take and center and think about what we are going to say and how we're going to say that so that's the way that I'm going to use that few seconds that we have there.

I'm going to talk today about the impact of the core indicators that we've had. We've been very fortunate to have Bill Sappenfield in Florida. We have had quite a journey related to preconception health and I want to sort of fast forward through about three or four years of that journey so that you see how we came to thinking and what we were thinking about for the future. We were a part of the work that Nan described with CDC back I think it was around I think it was 2005, 2006 and about that same time we had the opportunity to have a project called the Florida Vita grant. It was some money that the Attorney General had gotten in a settlement with a pharmaceutical company, $2 million dollars that we had over a two or three year period and Elizabeth Jensen is in the back of the room. She was one of our key people with March of Dimes helping to implement this. We wanted to improve preconception health for the women of

childbearing age through the provision of both health education materials and multi-vitamins. And what Elizabeth found as she started working with women is you know over 50% of our pregnancies aren't planned and where we've been going is to family planning and places like that and saying well when you're planning and thinking about getting pregnant you need to take multi-vitamins. Well as Dan Heath said you know you've got to get the right motivator. And so we came up with looking good, feeling good and helping women to think about this for their own health instead of a future oriented kind of a purpose. So that was a really great thing that we were able to do. Then the next thing that we had an opportunity to do was use some of our block grant dollars, 2.7 million as the recommendations were coming out of CDC we wanted to seize the opportunity to really pick what we thought was some low hanging fruit. We wanted to focus on that recommendation five that had to do with the inner conception period for women who had a previous adverse pregnancy outcome. And we have a system of Health Start Coalitions across our state who were able and ready to implement this kind of a project. So what we did is we put out a proposal plan. Everybody was going to get a base of $40,000 and then we would augment that money based on the poor pregnancy outcomes and the numbers of births that they had in their area. We had some requirements they had to meet the CDC recommendation and we wanted them to focus on either community outreach, provider education, or direct services. Those started in September of 2006 and they ended in 2007 but I'm happy to report that a lot of the coalitions felt that this was such important work that they've continued it and tried to incorporate it in more of a lifespan, life course type of approach. The next thing we borrowed heavily from California and again our partners in March of Dimes. In California

they had a program that was called, Every Woman Every Time and we got permission to look at that and have an umbrella that we call Every Woman Florida. Within that umbrella we have components for providers and for women. For the women it's Every Woman Every Day. And for the provider Every Woman Every Time. The other thing that we've done is to work with our March of Dimes prematurity group that's been around for six or seven years and get them engaged in thinking about the preconception period as well. So that's been a new addition for us. And the other thing is we're focusing it with a lot of social marketing kinds of techniques. We have a website that you can go to. You can get there in several ways so that when people hear the phrase Every Woman Florida they can get there even if they go to a dot org or a dot com or they spell it out. At that website we have a toolkit that has provider education fact sheets, patient education information, some evaluation and we also have linkages there for a lot of other helpful resources. As we have been embarking on this. You know Bill is one of our consciences. We kind of tend to leap right into programs and get going and not think about all those questions that ought to be asked. Like what does it mean? What do you include in preconception health? What are our issues? And what are the trends? What do we need to be focusing on? And how do we know if we've made a difference when we do it? So that's the back drop for the remainder of the talk. We've had…in implementing our process we're looking at having a report much like California did a report early on as Bill mentioned and we want to incorporate those preconception health indicators into the actual public health practice. We've had sometimes some staffing limitations even though we do count a full seven in our epidemiology section. We cobble that together by having students, we have fellows, we have staff that may not directly

report to Bill but that are doing data work related to MCH. So it may sound like we have a lot of staff with seven, but that is a really cobbled together picture. So with some of the staffing limitations that we've had we hire a student from the University of Florida who is getting her Master's and as a part of that work she is going to be doing our report and she's got to get that done by May so we know we're going to have a report by May. We've gotten some of our numbers in and we're learning a lot. We're learning a lot about what we don't know and our focus is going to be to describe that preconception health in Florida in that report. Most of what we are drawing from are the Prams and the behavioral risk factor surveillance survey and there are a couple of challenges with that we're going to talk about here. Bill says we have to talk about challenges not just all the good stuff. First of all not all of the Prams indicators are available in Florida. Some are new to Prams in 2009, some are optional and they're not on our Florida survey and those kinds of things that we don't have are those women who have a live birth and they reported smoking was currently allowed in their homes, we don't have that. Percentage of women having a live birth who visited a health care provider to be checked and treated for anxiety or depression during the 12 months prior to pregnancy. The percentage of those having a live birth who experienced depressive symptoms in pregnancy so other emotional support indicators that we know are important. Mentally abused by their partner, during the 12 months prior to pregnancy. That's a part of that life course thinking that you know that period before the pregnancy may be more important that during the pregnancy. A percentage that reported that they had adequate social emotional support, those that had hypertension when we were thinking about that cross-over between chronic disease and the MCH population and then also infections

related to HIV diagnosis within that…or testing within that year prior to the pregnancy. We also had some challenges with Prams in that prior to 2006 we had really good response rates and then in 2006 we actually had to shut our survey down because we had some data challenges. So we got back up and going about halfway through 2007 and we still haven't reached 60% on that and of course the new standard for CDC is 65% so that makes a challenge for us. We also have small sample sizes in Prams. And if we're going to be able to really look at some of the characteristics like age, race, ethnicity, education, income, marital status we need to have a bigger population. So what we have decided to do is to lump together three years of information, 2005, 2006, 2008.

Also another challenge is that we wanted to have some national comparison not just one state to another state or just ourselves and we don't really have that ability in Prams at this point. We know the CDC's working on this and we are really thankful for the technology using ponder which allows us to really pull out and look at those specific characteristics for ourselves and then C ponder which will let us look at other states but it's not national and in order to get to that national stuff we would have to really do some labor intensive work that we don't have the time and ability to do. We'd have to get permission from all of those states. And so what we decided to do was compare the overall estimate with the median across those other states and we thought that would give us a more stable number over time. Then the other components that we are using are from BRFSS. We again have that small sample size kind of issue. So once again we are combining years and even though we recognize that there is a big difference

between 2007, 2008 we think that we can use data methods to compensate for that. One of the other challenges with BRFSS is that the…some of the indicators are only asked every other year as already been mentioned and right now those indicators that we are intending to use from the BRFSS survey are the fruit and vegetable consumption five times a day, vigorous physical activity and whether or not they have been told that they have hypertension during pregnancy.

So what does all that mean for us in public health and how do we incorporate that into our practice? Well we have several areas that we are looking at currently. With our needs assessment we decided that we would break down a component that was women of childbearing age and we would ask the questions that we were asking about and surveying on of that population and specific to that population rather than just looking at pregnant women and infants, children and adolescents and then the children and adolescents with special health care needs. We set seven priority areas that we wanted to look at and these fit with the domains that Bill has already described to you. Even though we didn't have our indicator report yet we had the inside track since we had had Danielle and Bill on board telling us all along what kinds of things were going on. So these are our seven health care for uninsured and under insured women, obesity and physical exercise, unintended and unwanted pregnancy, psycho social health, preconception health screenings and education by providers, iron deficiency, anemia before, during and after pregnancy and tobacco use. We currently are in the process of rating those priorities as many of you are. We're looking at the kinds of things that Bill mentioned earlier about the impacts, the feasibility, whether or not it was a priority in our

state and what kind of thing that we could do about it in public health. Ultimately the program will take the information from our stakeholders and make a decision about how we set those final priorities. We are thinking in terms of the life course as we look forward to this and we know that preconception health is not the whole life course concept but we think it's one of our pathways of getting there. Proposed measures that are going to be selected are going to be selected would be whether or not an established measure, is it well researched, currently available, and potentially comparable to other states? We're really please to not be out there flying by the seat of our pants on these priorities as we have in the past. From the first preconception indicator report that I mentioned we're hoping to have by May. We've found like many of you that there's nothing comprehensive out there for us for us to be able to really use that pays attention to these kinds of indicators. So our partners and providers don't really know where we stand in Florida on preconception health. Some don't even know what we're talking about. So we're hoping that we would be able to use this in our partner's newsletters. We have a really good relationship with our college of OBGYN section in Florida. We have partnership with pediatricians and the family practice academy, the nurses associations and we're able to get information into their newsletters very frequently. We're often asked to speak at their conferences so we would do that. We would put out issue briefs that we could use with a variety of partners and we would focus those with messages that resonate with that particular group. We have a lot of other collaborative efforts. I've mentioned March of Dimes. We also have worked really strong with a variety of other groups in the state especially our Florida Healthy Start association and we have five federal Healthy Start projects in the state.

We work very closely with them. And then this will give us good background information to work on grant proposals. We also have one of those first time motherhood grants that we're really proud of and working hard to make sure that again it's got that life course kind of perspective. I mentioned that we have the March of Dimes prematurity work group. They've been around for six or seven years looking at prematurity issues and we have talked with them about having preconception health be one of their focus areas and they've been very agreeable to that. It will help them to prioritize the large number of issues that they discuss all of the time and give them some of the indicators that they need and then be able to track what's going on with some of those selective issues. They're very excited about the work, too. So we've had multiple efforts, looking at our performance measures, the monitoring, grant proposals…so we're very excited to have these kinds of efforts in place. We are very early in our implementation phase but we think that these components that we talked about today the report, incorporating into practice are going to be very helpful to us. We need indicators that are not currently being collected. So not everything is good. And Bill says we have to talk about that because when we talk about it with you our colleagues you may have some ideas that we could build upon and generate additional work that we need to do. We need better indicators. We need not just how many, but we also need to think about whether or not the care is appropriate. Is the prevention practice being followed by those women that we're serving? So we need to be thinking beyond just those numbers that we've been talking about today. And we also need some clear evidenced based policies and programs that will provide the direction for even better indicators for our future. So we look forward to working with you and hope that this has been helpful.